HOPE, CHRISTOPHER WILLIAM (CHRISTOPHER)

AUTHORIZED TO PROVIDE PSYCHOLOGICAL SERVICES IN ONTARIO

NO DISCIPLINE OR OTHER PROCEEDINGS

College of Psychologists of
Ontario https://members.cpo.on.ca/public_register/show/21130

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Heffernan v Hope, 2022 CanLII 95984 (ON HPARB), <https://canlii.ca/t/jsg5p

24. The Committee noted that the Respondent submitted that the report was in fact favourable to the Applicant, as he concluded that the Applicant's diagnosed condition fell "outside" and therefore exceeded the definition of a Minor Injury. The Committee found the report to be confusing and challenging to understand. It expressed concern that a lay person reading the report might reasonably conclude that the injury was unrelated to the accident and was so minor as to not be considered a Minor Injury. The Committee indicated its belief that the way the Respondent's report was written left much up to the interpretation of the reader and a number of conflicting conclusions could be drawn from the report. The Committee was of the belief that the way the report was drafted presented a risk to the public.

25. The Committee took the view that the impact risk in this case was high, noting that reports of this nature can affect a client's ability to access insurance funds for treatment and may also inform subsequent medical care. The Committee stated that unclear reports can have serious consequences for clients.

26. The Committee further took the view that there was a significant recurrence risk in this case. The Committee noted that the Respondent had a history before the Committee, in which it had previously provided the Respondent with Cautions and Advice relating to the above-noted concerns. In 2013, the Respondent also agreed to an Undertaking related to concerns that he may have rendered a professional opinion which was not based on current, reliable, adequate, and appropriate information.

27. The Committee expressed the belief that the Respondent's history suggested a pattern of conduct related to issues in report writing which represented a significant recurrence risk. It appeared to the Committee that the previous Cautions, Advice and Undertaking (which involved a period of Peer Mentorship) did not adequately remediate these concerns.

28. The Committee decided that it would be appropriate and in the public interest to ask the Respondent to enter into an Undertaking with the College regarding concerns around clarity and comprehensibility in report writing. The Undertaking consisted of a period of Supervised Practice to provide the Respondent with the required support and oversight to

address the Committee's concerns. During the period of Supervised Practice, the Respondent would only be permitted to conduct assessments under the guidance and support of a Peer Supervisor who was to review and co-sign all reports.

29. In his letter requesting the Review, the Applicant challenged the reasonableness of the Committee's decision.

30. The Applicant referenced the Committee's statement that the possible impact risk was high in this case, submitting that he was denied income replacement benefits for over 10 months, resulting in pain and suffering for him and his family.

31. The Applicant further noted the Committee's reference to the Respondent's history with the College, and its opinion that there was a "significant recurrence risk in this case". The Applicant questioned why the Committee would state that "the previous Cautions, Advice and Undertaking (which involved a period of Peer Mentorship) did not adequately remediate these concerns" yet provide him with a similar type of remediation for a shorter amount of time.

32. Counsel for the Respondent submitted that the Committee's decision was reasonable. Counsel advised the Board that the Respondent acknowledged the Committee's criticisms of his report, noting that the Respondent had already fully completed the requirements of the Undertaking as of the date of the Review.

33. Counsel submitted that the Committee's disposition in this case was more "onerous and significant" than the 2013 remediation referenced by the Committee in its decision, and hence represented an appropriate level of progressive remediation.

34. In response to a question from the Board, the College Representative advised that, unlike the 2013 remediation, which was more akin to a mentorship, the Undertaking in the current matter imposed a period of Practice Supervision. During this period, the Peer Supervisor was required to oversee all assessments done by the Respondent. The Peer Supervisor was required to co-sign any assessment reports by the Respondent, and the Peer Supervisor was ultimately accountable for any such assessment reports.

41. Pursuant to section 35(1) of the Code, the Board confirms the Committee's decision to accept an Acknowledgement and Undertaking from the Respondent regarding the clarity and comprehensibility of his assessment report. The full details of the Undertaking are set out in Appendix A.

Appendix A
ACKNOWLEDGEMENT AND UNDERTAKING OF [the RESPONDENT] TO THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO

1. I, [the Respondent], acknowledge that the Inquiries, Complaints and Reports Committee (ICRC) of The College of Psychologists of Ontario (College) is concerned about the following

aspects of the professional services I have provided, as identified in the complaint lodged by [the Applicant] dated March 2, 2021:
• That the report I produced may have lacked clarity and comprehensibility.
2. In light of these concerns, I hereby undertake the following:

TERMS, CONDITIONS. OR LIMITATIONS

3. I understand and agree that I am bound by the terms of this Undertaking from the date upon which the ICRC releases its decision in this matter.
4. I will undergo a period of Supervised Practice for a period of six months from the date the ICRC releases its decision. This period of Supervised Practice will focus on clarity and comprehensibility in report writing.
5. I will only conduct Assessments and provide Psychological Services under the guidance and support of a Peer Supervisor.

27. I understand that when the ICRC's decision is released, a notation and synopsis of this Acknowledgement and Undertaking will be available on the Public Register. Thereafter, the notation and synopsis will be removed once it is confirmed in writing that the Acknowledgement and Undertaking is no longer in effect.

28. I understand that if the Peer Supervisor does not provide a final report indicating that the acknowledged concerns, above, have been appropriately remediated in the public interest, I will not be considered to have successfully completed this Undertaking. On that basis, the Registrar may initiate a new investigation into this matter, in accordance with the Health Professions Procedural Code, which is schedule 2 to the Regulated Health Professions Act, 1991, S.O. 1991, c.18.

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K.K. v Aviva General Insurance, 2020 CanLII 87927 (ON LAT), <https://canlii.ca/t/jblpg

[46] The applicant was denied ongoing IRBs after September 27, 2017 on the basis of a Multi-Disciplinary Report dated September 14, 2017[33]. This report consisted of a physiatry assessment of Dr. Alborz Oshidari, a psychology and a neuro-psychology assessment of Dr. Christopher Hope and a functional capacity evaluation by occupational therapist Brenda O'Grady.

[47] I also give little weight to this report. In his physiatry assessment, Dr. Oshidari was unable to detect any organic cause for the applicant's physical limitations. His opinion that the applicant did not suffer from a substantial inability to perform his pre-accident employment of a taxi driver does not account for any psychological impairment the applicant sustained in the accident. Dr. Oshidari found that the applicant appeared to be in a moderate degree of psychological distress as the encounter was dominated by pain-focused and self-limiting behaviour.

[48] The psychology assessment of Dr. Hope states that the applicant told him he tried to return to work after the accident but was not successful. He was not able to continue because he found it was too difficult focusing with people talking in his vehicle and he was too anxious.

[49] Dr. Hope found that the results of his psychometric testing were invalid because of probable negative response bias and symptom overreporting. He found that a psychological diagnosis could not be offered. He went on to say that this finding did not rule out the possibility that the applicant was experiencing genuine symptoms of psychological distress. This opinion of Dr. Hope is contrary to the earlier diagnoses of Dr. Schmidt and Dr. MacLeod. It is also contrary to the later diagnoses of Drs. Sivasubramanian[34] and Corbin[35]. I give more weight to the opinions of Drs. Schmidt, MacLeod, Sivasubramanian and Corbin. Their diagnoses take into account the negative response bias and symptom overreporting identified by Dr. Hope.

[50] Dr. Hope's Neurocognitive Assessment of the applicant found the applicant appeared to have sustained a mild traumatic brain injury. He provides the opinion that a small percentage of individuals will continue to report prolonged concussive symptoms possibly attributable to psychological factors. Dr. Hope's assessment does not recognize that the applicant had already been diagnosed with Major Depressive disorder arising from the accident. For this reason, I am unable to give his opinion on the applicant's ability to return to work much weight.

55] Dr. MacLeod provides a reasonable explanation as to why the applicant may have performed so poorly in the testing that was part of the multi-disciplinary assessments. Dr. MacLeod acknowledges that the applicant's response style on psychological measures created some challenges in formulating a diagnosis.

[56] Her opinion is corroborated by Dr. Corbin who pointed out that English is a second language for the applicant and the psychometric test he administered was validated using native English speakers. It is also corroborated by the opinion of physiatrist Dr. Fox who provided the opinion that there are non-organic factors at play in the applicant's presentation. Dr. Fox stated that while the applicant was noted in a previous psychological examination as over-reporting symptoms, this does not necessarily imply that he was over-reporting his physical symptoms, but rather non-physical symptoms are perhaps contributing to his presentation during the assessment. Dr. Fox recommended that the applicant would benefit from a multidisciplinary pain program to deal with his self-limiting behaviour due to fear of pain.

[57] Aviva submits that while Dr. MacLeod disagreed with Dr. Hope's diagnosis, she did not provide an opinion on the claimant's ability to work. This submission of Aviva is contradicted by the fact the it was Dr. MacLeod who signed the July 13, 2017 disability certificate certifying that the applicant was substantially unable to carry out the essential tasks of his pre-accident employment.

[58] For the reasons provided above I am satisfied that the applicant remained eligible for

IRBs for the full 104-week period after the accident. I am of the view that Aviva ignored the applicant's psychological diagnosis when it terminated the benefits as of January 21, 2017. I am also of the view that Aviva again chose to ignore the applicant's diagnosis of psychological impairments when it terminated the benefits for a second time after receiving the September 14, 2017 Multi-disciplinary Assessment.[39]

[92] When Aviva terminated the applicant's IRBs as of January 21, 2017, it accepted Dr. Schmidt's incorrect conclusion that the applicant had returned to work full-time. Aviva relied on the surveillance report of Norman Lalonde Investigations without considering the fact that the majority of the income the applicant received from September 15 to January 21, 2017 was from the rental of the taxi cab as opposed to the applicant driving the cab himself.

[91] I am satisfied on the balance of probabilities that the applicant is entitled to a lump sum award on the income replacement benefits he is entitled to. I find the applicant's claim for IRBs was unreasonably denied for the following reasons:

i. Aviva failed in its ongoing adjustment of the claim to give recognition to the fact that the applicant suffered psychological impairments in the accident despite its own assessors diagnosing the applicant with psychological impairments.

ii. Aviva failed to recognize the severity of the psychological impairment. despite the comments of its own assessors. Well over three years after the accident, Aviva approved a plan for further psychotherapy and did not reconsider whether the applicant was entitled to ongoing IRBs.[56]

[92] When Aviva terminated the applicant's IRBs as of January 21, 2017, it accepted Dr. Schmidt's incorrect conclusion that the applicant had returned to work full-time. Aviva relied on the surveillance report of Norman Lalonde Investigations without considering the fact that the majority of the income the applicant received from September 15 to January 21, 2017 was from the rental of the taxi cab as opposed to the applicant driving the cab himself.

[93] Aviva's submissions recognize that Dr. Hope found that the applicant may have sustained a mild brain injury but failed to recognize his proviso that the applicant may have been experiencing genuine symptoms of psychological distress.

[94] Aviva's submissions mention the assessment of Dr. Sivasubramanian but fail to recognize his diagnosis that the applicant suffered from posttraumatic stress disorder due to the March 2016 accident.

[95] Aviva refers to the assessment of physiatrist Dr. Fox but fails to recognize that Dr. Fox recommended the applicant be referred to a pain management clinic.

[96] Most strikingly, Aviva failed to recognize the June 2019 IE assessment of Dr. Corbin diagnosing the applicant with post-traumatic stress disorder. Dr. Corbin noted the relative

severity of Mr. [K]'s psychological difficulties and found that likely that he was not yet at maximum medical improvement.

[97] Insurers have an obligation to continue to adjust claims made under the Schedule. I find that Aviva unreasonably refused to pay IRBs to the applicant in the face of the solid evidence that the applicant suffered serious psychological impairments as a result of the accident

[98] Aviva never posed the question to any of its IE assessors who completed assessments more than 104 weeks after the accident if the applicant met the requirement for ongoing IRB benefits.

[99] For the reasons provided above I am satisfied on the balance of probabilities that Aviva unreasonably withheld payment of the IRBs claimed.

[100] O. Reg. 664 allows me to order a lump sum award of up to 50% of the income replacement benefits found to be owing. The applicant asks for 50%. Aviva made no submissions on the percentage.

[101] I am satisfied that 50% is appropriate in this case because of Aviva's actions in essentially completely ignoring the fact that the applicant suffered psychological impairments in adjusting the claim.

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Morphet v Pafco Insurance Company, 2020 CanLII 94808 (ON LAT), <https://canlii.ca/t/jbwx1

[27] The applicant underwent a Neurocognitive IE assessment with Dr. C. Hope, neuropsychologist, to assess the OCF-18 in dispute and he issued a report dated June 26, 2019[26]. The applicant reported continued pain in the areas of her neck, head, shoulder, jaw, mid to lower back, legs, and right wrist. The respondent submitted this was the first time the applicant reported shoulder pain. I disagree as I had noted in paragraph 18 that within the IE FAE report of December 21, 2017 it was noted the applicant reported the pain in her neck radiated to her right shoulder blade. Dr. Hope noted the applicant reported she is sleeping 3-4 hours/night and has anxiety about everything. Dr. Hope could not provide a diagnosis, nor opine if she reached maximum medical recovery ("MMR".) This was because he found validity issues with the test results because of symptom over-reporting and negative response bias on cognitive testing. Dr. Hope further opined that as a result it is not reasonable to accept her self-report of her impairments as valid. Dr. Hope further noted: "Over-reporting and invalid assessment results, however, do not rule out the possibility that Ms. Morphet is experiencing genuine symptoms of distress. She has a long pre-accident history of difficulties with pain, which could reflect a tendency to somatize her distress. Thus, the presence of a somatic symptom disorder cannot be ruled out. Unfortunately, in the context of the current assessment results, this diagnosis is not supported." Dr. Hope determined that as a result of no valid evidence to support a valid neuropsychological impairment, the OCF-18 was not reasonable

and necessary.

[28] From the list of documents reviewed, it appears Dr. Hope reviewed pertinent medical documents including the records of Dr. Murphy from 2009 to 2018, the prior IE multidisciplinary IE assessment reports, the 2018 addendum report of Dr. Fox, Quinte medical records, imaging results, and the disputed OCF-18. From this evidence, I find Dr. Hope would have been able to understand the applicant suffered from chronic back pain prior to the accident, and that she still continued to receive ongoing treatment from Dr. Murphy post-accident to help with managing her ongoing pain. While I accept that Dr. Hope was unable to provide a diagnosis that she suffered from a neuropsychological impairment, nor was he able to determine if she reached MMR due to issues with validity on the test results, I do not accept that his report is definitive in determining whether this OCF-18 is reasonable and necessary for reasons I will address below.

[29] I find the OCF-18 to be reasonable and necessary for the following reasons. The applicant was diagnosed with chronic pain prior to the accident. I find the accident has exacerbated the chronic pain in her low back and that she has developed pain in her neck and coccyx region since the accident. I accept she experiences pain in her legs since the accident and rely on what has been noted by Dr. Murphy in May 2016, which I referenced within paragraph 10. I find the IE FAE report, second FAE report, and Ms. Alexander's occupational therapy assessment report all provide support that the applicant required the use of a cane to assist her with balance and walking. While I accept that there is no evidence to support the applicant suffers from a cognitive impairment as a result of the accident, I am persuaded her anxiety levels have increased post-accident. The increase in her anxiety levels has impacted the increase in her BPI scores post-accident and I rely on Dr. Murphy's CNR dated June 11, 2018[27] which supports this finding. From the results noted on the FAE and second FAE, I accept that the applicant's pain severely limits her ability to perform her ADLs which is a result of the accident. Prior to the accident she was receiving nerve block injections and was prescribed pain medication by Dr. Murphy, but she also was working at a job which she had for 5 years and ambulated without the use of a cane. The previous activities she enjoyed prior to the accident which she is limited, or unable to currently perform were consistently described and reported to a number of assessors. I find the applicant had issues with poor sleep quality both prior and post accident, but I find her level of reported pain has significantly increased post-accident which is supported by Dr. Murphy performing lidocaine infusions and increasing the number of prescribed pain medications post-accident.

[30] While the respondent submitted she already attended occupational therapy sessions in August - November 2016 and learned strategies to address her chronic pain through the use of mindfulness which she found useful, I find the proposed goals within the disputed OCF-18 are supported. I find the applicant's pre-existing condition was exacerbated by the accident, the pain in her neck has not resolved and has contributed to her impaired level of functioning post-accident as I referenced within the paragraph above. I am persuaded by the recommendation made by Ms. Alexander for a referral for pool therapy but not for physiotherapy. This is because the applicant had reported physiotherapy had not worked to manage her pain post-accident.

Further, she reported to Ms. Maja Wojcik-Marano, vocational evaluator, in January 2019 that her pain was aggravated following physiotherapy treatment. In addition to the applicant's chronic pain, it was also noted that she suffers from low mood and increased reliance on her husband to assist her due to her functional limitations and inability to carry out her ADLs, which I accept have been impacted by her impairments post-accident.

[31] I am also persuaded by Dr. Oliver's finding that focusing on clarifying and resolving her reported physical symptoms should resolve the psychological symptoms. The evidence for the hearing supports there has been no psychiatric or psychological treatment received by the applicant since the accident. However, I accept the recommendations made by Ms. Alexander are reasonable and necessary to address the applicant's psychological symptoms which neither Dr. Oliver, nor Dr. Hope could diagnose, but neither ruled out that she is experiencing psychological symptoms. I accept that the deterioration in the applicant's level of functioning both physically and psychologically since the accident have been supported in the numerous assessment reports and the CNRs of Dr. Murphy. I find the recommendations made by Ms. Alexander are reasonable and necessary to achieve the proposed goals outlined within the OCF-18.

CONCLUSION

[32] For the reasons I outlined above, I find the applicant is entitled to the OCF-18 for occupational therapy in the amount of $7,091.50 and interest pursuant to s. 51 of the Schedule.

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Applicant v Security National Insurance Company, 2019 CanLII 101545 (ON LAT), <https://canlii.ca/t/j33sz

[16] Two IE neuropsychological reports dated September 25, 2017 were issued by Dr. C. Hope, neuropsychologist. Within one of his reports he noted that he deferred his analysis of a mental behavioural impairment pending a review of an OT report. The respondent sent the applicant a letter dated October 12, 2017 which provided the applicant with a copy of both of Dr. Hope's reports and advised the applicant an OT CAT IE was required to provide catastrophic impairment determination. Dr Hope's report noted: "Psychologically, an analysis of Mental and Behavioural impairment under Chapter 14 is deferred pending a review of the OT report". The applicant had agreed to attend an OT CAT IE.

[17] The applicant followed up with the respondent by letter dated November 24, 2017 to address the OT CAT IE and noted the applicant requires notice from the respondent that if they require the applicant to attend an OT CAT IE, the applicant will need to receive this notice by December 8, 2017, or the applicant would be filing an appeal application with the Tribunal. The respondent submitted that it failed to schedule this IE and further submitted it is unclear why they did not schedule the OT CAT IE.

[18] The applicant submits the respondent should not be able to now request a CAT OT IE

to determine whether the applicant has a catastrophic impairment as the respondent has not complied with s. 45(3)(b) of the Schedule and there has been a significant delay on the part of the respondent in issuing its notice. The applicant did not receive the request for this IE until 3 days before the scheduled case conference with the Tribunal which was four months after the applicant filed their appeal application with the Tribunal.

[19] The respondent submits they responded to the OCF-19 which was signed by the applicant within 8 business days of receiving it and therefore they have complied with s. 45(3) of the Schedule. The respondent relies on the decision issued by the Financial services Commission of Ontario ("FSCO") Rojas v. Coachman Insurance Company.[3] In that case the insurer responded to the applicant's OCF-19 several months after receiving it. The applicant then refused to attend the scheduled IEs and took the position that the OCF-19 should prevail and the applicant should be deemed catastrophically impaired due to the respondent's failure to respond to the OCF-19 within the prescribed 10 days noted within the Schedule. The arbitrator noted the there is no regulatory consequence set out within the Schedule when an insurer fails to comply with the timelines set out within s. 45 of the Schedule and as a result, the arbitrator noted he had no authority to insert new words and consequences into the Schedule by arbitral decision.

[20] While I agree with the applicant that the respondent failed to comply with s. 45(3)(b) of the Schedule, as the respondent's letter dated March 10, 2017 in response to the initial OCF-19 was not sent to the applicant within 10 business days as prescribed by the Schedule. The language noted with s. 45(3)(b) of the Schedule is clear that after an insurer receives an application for catastrophic impairment determination, prepared and signed by the person who conducted the assessment or examination [emphasis mine], the insurer shall provide notice to the applicant within 10 business days notifying the applicant that the insured has determined the impairment is not catastrophic…I find the respondent was required to respond within 10 business days to the initial OCF-19 it received on February 11, 2017. There is nothing found within s. 45(3) that the OCF-19 must also be signed by the applicant. However, I find the Schedule remains silent with respect to consequences for non-compliance with the timelines noted within s. 45(3) of the Schedule. I find Rojas to be persuasive as it analogous with this case in relation to the insurer not responding to the OCF-19 within 10 business days. The reasons for which the denial was based does not constitute medical reasons as the letter provided no further details about the applicant's condition, what medical information the respondent relied on to form the basis of its denial, or what further medical information it required. However, as a result of the Schedule remaining silent regarding the consequence of non-compliance, it does not mean the applicant is entitled to a designation of catastrophic impairment determination, nor that the applicant is not required to attend an OT CAT IE. The respondent has an ongoing requirement to continually adjust the applicant's claim and I will address the reasonable and necessary component of the OT CAT IE further below.

26] I find the respondent has proven on a balance of probabilities that the OT CAT IE is reasonable and necessary. The application is stayed pending the applicant attending an OT CAT IE as per the terms noted within my order below. The applicant had previously agreed she

would attend an OT CAT IE if the neurocognitive psychological IE assessor required one to formulate their opinion. I therefore find the neurological assessment was conducted with the assumption that if required, the applicant would attend an OT CAT IE. I find the respondent's neuro-psychological assessment is incomplete as Dr. Hope has noted within his report that he has deferred providing an opinion on mental behavioural impairment as it relates to chapter 14 of the AMA Guides pending a review of the OT CAT IE report. While I accept that there have been significant delays which have resulted from the respondent's inaction in scheduling the OT CAT IE sooner and no explanation was provided by the respondent, this does not dissuade me from finding that the OT CAT IE is reasonable and necessary. I will provide my reasons in further detail below.

[32] The applicant submitted she would suffer significant prejudice if a stay is granted as this would further delay the hearing another 5-6 months. The respondent submitted a date for the hearing has not been scheduled and potential prejudice to the applicant could be minimized by scheduling the OT CAT IE promptly. The respondent submitted the CAT OT IE will assess the applicant's functional abilities in relation to her activities of daily living for the purpose of evaluating mental and behavioural impairment and this will provide Dr. Hope with the necessary understanding of the applicant's mental and behavioural functioning under Criterion 8. The respondent relies on 17-004109 v. Intact Insurance Company[9] in which adjudicator Hines concluded it would be procedurally unfair to not allow the respondent to assess whether the applicant sustained a catastrophic impairment under criterion 8 if it were not allowed to submit evidence in a case where the stakes are high.

[33] While the applicant has attended only two CAT psychological IE's, the applicant submitted she has attended only one psychological assessment of her own and this information should suffice with assisting the Tribunal in determining whether she sustained a catastrophic impairment.

[34] It is the respondent's position that determining whether the applicant is catastrophically impaired is a new issue for the respondent and the OT CAT IE is required to be able to properly adjust the claim for catastrophic impairment. The applicant disagrees that catastrophic impairment is a new issue as the respondent was in receipt of the OCF-19 for 22 months prior to the respondent issuing its CAT OT IE notice December 11, 2018. The applicant submitted the notice which requested the applicant attend the OT CAT IE was sent by regular mail to the applicant mid December 2018, despite the applicant filing her application with the Tribunal on August 20, 2018.

[35] While the applicant conceded there is a reasonable nexus between the OT CAT IE and the applicant's catastrophic impairment determination, the applicant submitted the IE would provide little value as an OT is not qualified to provide an opinion whether the applicant suffered a marked mental or behavioural impairment under the American Medical Association Guides ("AMA Guides"). The applicant further submitted that Dr. Hope reviewed an extensive amount of documentation (14 pages of listed records), conducted 11 hours of testing, and elicited much of the same information during his interview as an OT would, and this should be

sufficient to provide a determination of catastrophic impairment.

[36] I have found the OT CAT IE is reasonable and necessary. I agree that there is a reasonable nexus between the OT CAT IE and the determination of catastrophic impairment, Further, it was in part the applicant's agreement to undergo an OT CAT IE and in the absence of the OT CAT IE report it has resulted in Dr. Hope's neurological assessment being incomplete. I recognize the applicant has been prejudiced as a result of the delays with regards to respondent's failure to not schedule the OT CAT IE sooner. I do not accept that the issue of catastrophic impairment is a new issue. The respondent has known of this issue since the applicant applied for catastrophic impairment determination in February 2017. However, despite the significant delays to date, I recognize the respondent needs to properly adjust the claim and I find there would be significant prejudice in this case which would outweigh the prejudice to the applicant if the respondent was not provided with the opportunity to obtain an OT CAT IE. I find the analysis provided by Adjudicator Hines in 17-004109 v. Intact Insurance Company to be persuasive, recognizing there were some distinguishing factors in that case as the respondent in that case did not have its own neuropsychological and psychological IE reports to address the reports already obtained by the applicant.

[37] In this case, while I accept that the applicant's own treating psychologist who issued a report on behalf of the applicant was able to provide an opinion on catastrophic impairment determination without an OT report, I do not find on this basis the OT CAT IE is not reasonable and necessary. As a result of Dr. Hope not providing an explanation within his report as to why he deferred providing an opinion regarding catastrophic impairment determination until he reviewed the OT report, or noting he could not provide an opinion without an OT report, I will not surmise that Dr. Hope can provide an opinion on catastrophic impairment determination without reviewing a report from an OT. This reinforces the reasonable nexus between the OT CAT IE and the applicant's injuries. As the applicant has attended two prior CAT IE's, I do not find the OT CAT IE to be excessive.

CONCLUSION

[38] The applicant is not precluded from proceeding with their application pursuant to section 55(1)2 of the Schedule. The respondent's catastrophic impairment denial letter dated March 10, 2017 did not comply with the timeline requirement noted within s. 45(3)(b) of the Schedule. The OT CAT IE notice dated December 11, 2018 did not comply with s. 45(3)(b) of the Schedule. I find the OT CAT IE to be reasonable and necessary. A stay of the application is granted but with the following terms as noted within my order below

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M. M. v. Optimum Insurance Company Inc., 2018 ONFSCDRS 83 (CanLII), <https://canlii.ca/t/jqb16

At the resumption on January 11, Optimum brought a motion seeking an order that Dr. Christopher Gallimore, the author of the Executive Summary to the Applicant's CAT Reports, be

barred from testifying and further that the two reports which had been served in accordance with my order of November 27, 2017 not be permitted nor the authors permitted to testify. On January 4, 2018, the Applicant had served a report from psychiatrist Dr. Leslie Kiraly,[9] in response to Optimum's Psychology Assessment Report by Dr. Christopher Hope,[10] and an Addendum Report by Dr. Gallimore.[11] Optimum also sought leave to file a further Addendum Report prepared by its psychologist, Dr. Hope, in response to Dr. Kiraly's Report Exhibit 24 which had been served in accordance with my order of November 27. Leave was granted.

I ruled that the Optimum's motion to bar Dr. Gallimore from testifying was brought too late. The best resolution to allow procedural fairness for both parties was to permit the reports and testimony (if required) to be filed as part of the record subject to Optimum's ability to file an Addendum report responding to Dr. Kiraly's Report for which leave had been granted. Dr. Hope's Addendum Report was served in accordance with my order and was marked as Exhibit 28.
[]

Optimum's impairment assessment is set out in the Executive Summary prepared by Dr. M. Khaled dated September 29, 2017[26] and the Executive Summary Addendum dated November 15, 2017.[27] Optimum's breakdown of impairments totalling 41% was sent to the Applicant's counsel in the letter by Pinnacle Adjusters Group[28] as follows:

Physiatry	13%
Neurology	17%
Ear Nose and Throat ("ENT")	5%
Neuropsychology	14%

Dr. Christopher Hope opined that it was not possible to give an accurate percentage estimate from a Mental Behavioural Disorder. Dr. Khaled could not give a numerical impairment class rating under Criterion 8. A significant area of difference in the WPI of the parties is that Optimum has included no rating under the heading "Mental Behavioural".[29] Both parties include 14% under headings of "Head Injury" in Dr. Gallimore's opinion and under "Neuropsychology" based on the report and opinion of Dr. Zakzanis. Dr. Gallimore included a further 14% under "Mental Behavioural" and Dr. Zakzanis agreed that the Mental Behavioural impairments are different than the neuropsychological impairments which relate to her head injury and resulting cognitive impairments.
[]

The professional witnesses' oral evidence on the impairment of the Applicant under the Mental Behavioural Disorders is that of Mr. Beedling, Dr. Robinson, Dr. Hope, Dr. Kiraly and the family doctor.[57] Mr. Beedling is a psychotherapist and therefore cannot provide a diagnosis but I have the treatment plans signed by Dr. Mills who was Mr. Beedling's supervisor which do set out his opinion and diagnosis as an expert psychologist over the three years since the accident and as support for the ongoing treatment. With the exception of Dr. Hope, all the experts have had more than one occasion to assess the Applicant and therefore I must give more weight to

their opinions than to that of Dr. Hope.
[]

Included in the list submitted by Dr. Khaled was a psychologist. The assessor chosen was not the psychologist who had assessed the Applicant to advise Optimum in responding to accident benefit claims. Rather, Optimum retained two neuropsychologists, both of whom were qualified to assess both the neuropsychological impact of the mild traumatic brain injury the Applicant had suffered and the Mental Behavioural impairments. Each was assigned only one part of the assessment: Dr. Christopher Hope was asked to provide an independent assessment and rating for the Mental Behavioural impairments and Dr. Konstantin Zakzanis was asked to assess the neuropsychological impairment and give a rating for the mild traumatic brain injury.

Dr. Hope provided two reports. In his first, he refused to provide a rating because he concluded that, "in the absence of valid evidence of a significant psychological impairment that could be attributed directly to the accident in question, I give no rating". He came to that conclusion because he determined that the Applicant was over-reporting her symptoms and that the psychometric testing results that he had were not valid. I give his opinion no weight for the following reasons.

I do not share Dr. Hope's view that there is "no valid evidence of a significant psychological impairment". I find such evidence in that of Dr. Liao, Dr. Kiraly, Mr. Beedling and Dr. Robinson, and in the medical history set out in the reports of Dr. Robinson and Dr. Mills as well as in the clinical notes and records of those treating the Applicant. I reject the opinion of Dr. Hope that the Applicant is exaggerating her symptoms and could not be rated. He does not dispute that she suffers mental behavioural impairments. His information on her history was incomplete. He did not know that the Applicant had suffered other recent personal losses due to other motor vehicle accidents. Dr. Robinson did know about these losses and indicated that these were complicating factors impacting on her emotional and mental outlook. Further, when Dr. Hope reviewed in his testimony under cross-examination the questions that he believed had been answered in a manner that indicated exaggeration, the answers that he recorded during the Applicant's testing were consistent with her evidence. She could not truthfully have answered them any other way. I find the more probable explanation for the answers in the testing that is consistent with the other evidence I have is the explanation given by Dr. Robinson, that is, that the answers were indicative of an individual overwhelmed by the issues facing her.

I was also troubled by Dr. Hope's reference in his report to the Applicant making a workplace injury claim even though her injury had completely healed prior to the accident and forms no part of the issues in this case. None of the other psychologists regarded this as significant in the psychological assessment. When questioned, Dr. Hope indicated that, based on this claim experience, her answers were influenced by the potential for gain. He had no more information than that she had made the claim and the injury was resolved. His opinion that she was probably exaggerating is not supported by his speculation on this claim. I also note that his work in providing opinions is almost exclusively for insurers. In all the circumstances and given

the other evidence I have, I find that his opinion and his refusal to provide a rating are not consistent with the rest of the evidence and were not appropriate in the circumstances.

Because Dr. Hope regarded the Applicant's test results as invalid he refused to provide a rating. There is no evidence that Dr. Khaled did anything else to identify a Mental Behavioural Disorder rating for her, despite the opinion of Dr. Robinson expressed on three different occasions as to the impairments suffered by the Applicant and the evidence of significant impediment to her function identified by Ms. Javasky.
[]

In my view, Dr. Khaled gave Optimum the outcome it wanted. I am satisfied on the evidence that he deliberately closed his eyes to relevant information that he should have taken into account. The Guides are specific that the history of medical treatment of the patient is an essential element in the assessment and rating. Dr. Khaled included Dr. Robinson's reports in his review of the records but when there is a specific issue related to the diagnosis of Mental and Behavioural Disorder requiring ongoing treatment, Dr. Khaled simply ignores the evidence and relies solely on Dr. Hope's refusal to accept the test results as valid. In cross-examination Dr. Khaled indicated that he focused on the assessments that were done for the CAT determination. He gave little if any weight to the past history.
[]

Issue 5 - Is Optimum liable to pay a special award because it unreasonably withheld or delayed payments to the Applicant?

To be successful in this award, the Applicant must establish that she is entitled to benefits that have been withheld. The only such benefits are the transportation costs in the amount of $1,440.00 which Optimum agrees should be paid if she is determined to be catastrophically impaired. This case was not about $1,440.00. It was about the availability of the additional funding for treatment. The catastrophic impairment case has moved with more alacrity than the other elements of the case with the OCF-19 being provided in April 2017, the assessments by Optimum in June and July 2017 and the addition of the issue in November 2017. Once the issue was focussed, reports came in quickly, too quickly for Optimum to agree that the process was fair.

Where I find fault with Optimum was the decision, whether by it or by its adjuster Pinnacle, to ignore the reports of Dr. Robinson and to use Dr. Hope instead. They used medical professionals who almost exclusively do work for insurers and there was clear evidence, on the part of Dr. Hope and in the advocacy of Dr. Khaled, that the assessment ratings did not assess the Applicant in accordance with its obligations to adjust the claim in good faith and in accordance with the Guides. There has not, however, been a delay in payments that would support a special award.

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Applicant v Scottish & York, 2018 CanLII 112111 (ON LAT), <https://canlii.ca/t/hw8ck

[12] On June 30, 2016, Dr. Christopher Hope, neuropsychologist, conducted the IE (the First Hope Report). At the IE, Dr. Hope noted that the applicant reported:

a. Anger;
b. Frustration;
c. Overwhelming stress due to his inability to work post-accident;
d. Loss in lifestyle and social life;
e. Low mood;
f. Lack of energy and interest in things he used to do;
g. Difficulty sleeping;
h. Pain;
i. Flashbacks;
j. Anxiety; and
k. Feeling sad and down as a result of his current limitations.

[13] Dr. Hope conducted a number of tests and found that the applicant reported a high number of variable somatic difficulties including malaise/fatigue, gastro intestinal difficulties and head pain.

[14] Dr. Hope concluded that the applicant suffered from subclinical levels of anxiety and low mood related to is inability to work and related financial difficulties. He declined to make a diagnosis.

[15] As a result of the First Hope Report, the respondent continued to deny the benefits requested.

[16] On August 24, 2017, the respondent conducted a multidisciplinary assessment of the applicant. This included a second psychological assessment by Dr. Hope (the Second Hope Report).

[17] In the Second Hope Report, Dr. Hope reported that the applicant:

a. Was not sleeping well;
b. Was less active and now overweight;
c. Was more angry than normal;
d. Was sad and trying to fight the feeling; and
e. Had problems with memory and attention.

[18] Again, Dr. Hope conducted a series of psychological tests. This time he found a higher than average number of variable somatic difficulties including malaise/fatigue, general poor health, gastrointestinal and neurological symptoms, and a heightened degree of stress/worry.

[19] As a result of the testing, Dr. Hope now diagnosed a somatic symptom disorder, with predominate pain related to the accident. He recommended that psychotherapy is warranted and stated that 12, 1-hour weekly sessions was reasonable and necessary.

[20] I find that the evidence supports the applicant's position that he was suffering from psychological issues related to the accident. His reported symptoms, both in the pre-screening, and the two IEs remained consistent throughout. He reported significant changes in his life since the MVA (inability to work, sadness, loss of lifestyle) that support this finding. I find that symptoms reported in the first IE and the second IE were very similar except that the applicant reported a slightly better mood at the second IE due to a modified return to work. The fact that only the second IE resulted in an official diagnosis is not determinative of the issue. A psychological diagnosis is not necessary: what is necessary is that the applicant was exhibiting psychological symptoms related to the MVA and that these issues were affecting his life, which I find they were. It is clear that the applicant was suffering from psychological symptoms (from the pre-screen and first IE) and therefore it was reasonable and necessary for the applicant to have had psychological assessment for the purpose of determining the issues and developing a treatment plan. In addition, the second IE concluded that the appellant should receive psychological treatment.

[21] Therefore, I find that it was reasonable and necessary that the applicant be provided with a psychological assessment to provide a plan for psychological treatment.

[22] I should note that the issue of whether the applicant's injuries fall within the MIG was not before me. Nevertheless, at the time of the denials, this was a live issue, the focus of the First Hope Report, and the basis for the respondent's denial.

[32] The respondent then sent the applicant to a multidisciplinary assessment provided by Dr. Jugnundan GP and Dr. Hope, neuropsychologist. Dr. Jugnundan's assessment was a paper review as he had seen the applicant one month before for a different assessment (Dr. Jugnundan's August 2017 Report). Dr. Hope's report is the Second Hope Report discussed above under issue 1.

[33] Dr. Jugnundan's section of the report is perfunctory. He states that the applicant has sought treatment, has returned to work and is fit. However, the facts do not support this conclusion. At the time of the report, the applicant had returned to work but with modified duties and reduced hours, and he continued to suffer from various symptoms and chronic pain. Indeed, in Dr. Jugnundan's August 2017 report, which included an in-person assessment – he found that because of the accident:

a. the applicant has stopped playing basketball, a significant social and exercise aspect of is pre-accident lifestyle;
b. he needs assistance with cutting the grass;
c. he is working half the hours he used to and on modified duties;
d. he has pain almost all of the time;

e. he has neck and back pain and headaches; and
f. his lower back pain has become chronic.

[34] Due to the inconsistencies in Dr. Jugnundan's reports, I reject his findings.

[35] The Second Hope Report, as previously discussed under issue 1, showed that the applicant suffered from psychological symptoms and recommended psychotherapy treatment which was approved.

[36] In considering the above reports, I prefer the evidence of Dr. Robertus. She conducted an in-person assessment and her conclusions were more in line with the symptoms complained of and the lifestyle changes that the applicant has experienced – most particularly his inability to return to full-time work and his modified duties. Both Dr. Robertus and Dr. Jugnundan concluded that the applicant was suffering from chronic pain. The treatment program suggested was specifically for treating chronic pain.

[41] For the reasons outlined above, I find the applicant is entitled to the psychological assessment, the multidisciplinary treatment program, the overdue payment of benefits and applicable interest.

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A.G. v. Wawanesa Mutual Insurance Company, 2017 ONFSCDRS 101 (CanLII), <https://canlii.ca/t/jq9l3

Further, Wawanesa's own reports were problematic. For example, Dr. Hunter's orthopaedic assessment recommended a psychological assessment. The, psychological assessment, completed by Dr. Hope, deferred a diagnosis while opining that A.G. exaggerated his physical, psychological and cognitive difficulties, but also that certain of A.G.'s test scores had "not been well validated on relatively recent immigrants living in North America", and that conclusions should not be drawn from his scores in isolation because of the unavailability of research within this population. An insurer functional abilities evaluation concluded that A.G. had restricted mobility and did not meet the strength requirements and positional demands of his pre-accident work (but that the test results could not be considered a valid representation of A.G.'s abilities because of what the author described as A.G.'s variable effort and invalid test results). There was also reference to depression and PTSD in A.G.'s family doctor's records that were not clarified until his family doctor testified. Added to this pre-hearing landscape was the fact that A.G. was an unsophisticated applicant who had suffered longer than expected following a previous accident.

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16-002234 v Unica Insurance Inc., 2017 CanLII 93459 (ON LAT), <https://canlii.ca/t/hq0l7

[24]. Dr. Natasha Browne is a psychologist who was retained by the applicant as part of the team from Omega Medical Associates to conduct a catastrophic assessment of the applicant.

Dr. Browne testified at the hearing and diagnosed the applicant with a major depressive disorder of mild severity and PTSD with a unique presentation of symptoms, including blackouts during times of increased stress and anxiety. Dr. Browne noted the applicant's difficulty coping with pain, anxiety and stress has manifested in loss of consciousness, but testified that the applicant met the test for PTSD without the blackouts. She also stated that if blackouts are not a symptom of PTSD, then they may be a symptom of panic disorder.

[25]. The respondent relies on the recommendation of Dr. Chris Hope that the applicant's reports of her symptoms and complaints be taken with caution. Dr. Hope is a neuropsychologist who was part of a team who conducted a catastrophic impairment assessment of the applicant at the request of the respondent. Dr. Hope testified at the hearing. He did not diagnose the applicant because he considered that the results from her psychological validity tests were invalid[2].

[26]. Dr. Hope testified that he could not conclude that the applicant was malingering[3] or consciously exaggerating her symptoms because he was not sure what was or was not intentional or conscious. Dr. Hope did not rule out the possibility that the applicant is experiencing genuine symptoms of psychological distress, but he questioned the reliability of the applicant. According to Dr. Hope, the applicant's validity test results were invalid because the applicant probably exaggerated her symptoms. Dr. Hope submitted his opinion that the applicant exaggerates her symptoms is supported because it is rare for a person to have a relapse of PTSD more than two years post-accident. We prefer Dr. Browne's opinion over Dr. Hope's for the following reasons.

[27]. According to Dr. Wiesenthal, the typical course for PTSD, for someone who has shown improvement, is that it is unlikely to regress unless there was a new or an additional stressor. In the applicant's case, there was an additional stressor that explains the PTSD regressions and the blackouts. That additional stressor was the near miss accident that the applicant experienced on June 15, 2015. It was not until she had the near miss that the applicant started experiencing the blackouts, which have been witnessed by three different health practitioners.[4] Dr. Hope's opinion is that the course of the applicant's PTSD is inconsistent because it did not follow the normal course of recovery. We give little weight to Dr. Hope's opinion because he did not consider any other reasons such as the near miss accident exacerbating the initial PTSD.

[28]. We also prefer Dr. Browne's assessment of the applicant over Dr. Hope because we accept the evidence that there were cultural factors that likely affected Dr. Hope's testing. Dr. Browne also administered a validity test and she did not find any instances of malingering. Dr. Browne's evidence was that one has to look at cultural factors that may also play a part in terms of a patient's presentation and her performance on the psychological validity tests. The applicant is of African descent who was born and raised in the Caribbean and came to Canada when she was 10 years old. Dr. Browne's evidence was that culturally, one must look at the history of mental health and mental illness and how it is displayed within the Caribbean community. This means looking at possibilities of defensiveness, the social stigma that is attached to mental health and how that may present in terms of the applicant wanting to

express her symptoms or at possible elevations in test measures. The psychological test measures are Westernized measures that are normed, primarily, on a Caucasian population, which does not mean that the results are invalid. However, Dr. Brown stated that there is research that mentions that, given the social history of the English speaking Caribbean population, being marked by oppressive power dynamics, colonialization, slavery and racism, if the client is of African heritage and the clinician is male and Caucasian, that can impact engagement or rapport building, which in turn could affect the validity testing.

[29]. Dr. Browne is a woman of African descent and so is the applicant. Dr. Browne testified that being a Black woman, she was more likely to build a rapport with the applicant than Dr. Hope, who is a white male. Dr. Hope testified that there was no indication that he did not develop a rapport with the applicant. However, he testified that a failure to build a good rapport could affect the test results. He also agreed that cultural and gender differences between a neuropsychological assessor and the patient will have an impact on their rapport.

[30]. We find that the applicant is not “exaggerating” or malingering and suffers from blackouts, which are a symptom of the PTSD and were triggered by the June 15, 2015 incident.

[62]. We disagree with the respondent`s submission that, because the applicant is able to engage in a number of activities without any demonstrated impairment, she should, at the most, have a moderate or Class 3 impairment. The respondent relies on Dr. Hope’s opinion that that the applicant’s symptoms are exaggerated, but for reasons already given, we found the applicant is not exaggerating her symptoms. Further, Dr. Hope did not provide any other impairment rating that addresses the alleged exaggeration of symptoms.

[66]. We reject Dr. Hope’s opinion that Dr. Brown’s impairment ratings are likely artificially inflated for the reasons listed earlier. His opinion is also weakened by the fact that the applicant’s blackouts have been witnessed by other health practitioners and that he provided no alternative level of impairment that Dr. Browne should have applied. For these reasons, we accept Dr. Browne`s opinion that the applicant sustained a Class 4 marked psychological impairment. This means that the applicant sustained a catastrophic impairment under s.3(2)(f) of the Schedule.